AUTHORIZATION FOR ADMINISTERING MEDICATION
Release and Indemnification Agreement

Part I: To be completed by parent/guardian

IF POSSIBLE, PLEASE HAVE THE CHILD TAKE MEDICATIONS BEFORE OR AFTER PROGRAM HOURS. I hereby authorize Cobb County P.A.R.K.S. staff to facilitate the use of medications by child as stated on this authorization. I agree to release, indemnify, and hold harmless Cobb County P.A.R.K.S. personnel from lawsuit, claims, expense, demand, or action against them for assisting my child with medication use, provided the staff comply with the authorized orders established below.

Child's Name_____ **Birth Date**_____ **Age**_____ **Sex**____

Check one:
_____ **Authorization for an antibiotic (10 days or less)**
_____ **Authorization for an over-the-counter medication**
_____**Authorization for other medications prescriptions (**PART II MUST BE COMPLETED)

Name of medication_____

Date of first dosage_____ **Effective from**_____ **to** _____

Dosage amount to administer during program hours_____

Date(s) and times to administer_____

Side Effect(s)_____

If the child will be taking more than one medication at a time, list the sequence in which medications should be administered._____

_____ _____
(Signature/Guardian Signature **(Date)**

PART II: To be completed by physician

Diagnosis_____

The information in Part I is accurate. Medication administration arrangements before and after program hours are not possible.

_____ _____
(Physician's Name (print) **(Telephone)**

_____ _____
(Physician's Signature) **(Date)**

This authorization form is complete. The original will be placed in the child's file. A copy will be placed in the Medication Log. The parent or guardian will receive a copy upon request.

_____ _____
(Staff Signature) **(Recreation Center)**
(Date)